Community Health Centers

AUTHORIZATION TO SEND/COMMUNICATE HEALTH INFORMATION

Fax Medical Records to: (802) 860-4313 E-mail Dental Records to: dentalxrays@chcb.org

Patient Name: _____ Date of birth: _____

Address: _____ Phone: _____

Reason for Release: Please choose the reason(s) for the release of your information:

☐ Coordination of care ☐ Patient copy ☐ Transfer care ☐ Second opinion
☐ Legal purposes ☐ Other (please describe):

Please choose all information you would like to have shared:

COMPLETE CHART:

☐ Complete Chart including Medical/Mental Health/Psychiatry. This includes past records from outside agencies that CHC has on file, including substance use disorder treatment records received from a program subject to 42 CFR Part 2 that may only be used and disclosed with written consent, except as permitted by law.

☐ ***Check here if you do not want your records from a Part 2 facility disclosed.***

Date range: ____/____/____ to ____/____/_____ **If no dates are specified, all records of this type will be shared.**

MEDICAL:

☐ All Notes for Medical Services Only. This includes past medical records from outside agencies that CHC has on file.

☑ Other (test results, appointments, billing information, etc.) Please describe: Last Physical, Current med List, Vaccines, Problem List, Last two OV notes

Date range: ____/____/_____ to ____/____/_____ **If no dates are specified, all records of this type will be shared.**

MENTAL HEALTH/PSYCHIATRY:

☐ All Notes for Mental Health/Psychiatry. This includes past records from outside agencies that CHC has on file, including substance use disorder treatment records received from a program subject to 42 CFR Part 2 that may only be used and disclosed with written consent, except as permitted by law.

☐ ***Check here if you do not want your records from a Part 2 facility disclosed.***

☐ Other (please describe):

Date range: ____/____/_____ to ____/____/_____ **If no dates are specified, all records of this type will be shared.**

DENTAL:

☐ Dental X-Rays

Date range: ____/____/_____ to ____/____/_____ **If no dates are specified, all dental x-rays from the last five years will be shared.**

☐ Other (please describe):

Information REQUESTED FROM:

Name:_____
Address:_____
_____
Phone:_____ Fax:_____

Information RELEASED TO:

Name: Appletree Bay Primary Care
Address: 1205 North Ave
Burlington, Vermont, 054508
Phone: 802-863-1313 Fax: 802-863-2396

Date upon which this consent will expire:_____

I understand that if I do not state the date of expiration above, then this consent will expire three years from the last date of service to me at CHC**. I understand that information released may include medical, psychiatric, mental health and/or drug and alcohol records.** I understand that my Medical Records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by state and federal regulations. A photocopy or facsimile of this consent is valid as is the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. This authorization may be revoked in writing to CHC at any time, except to the extent it has already been acted upon. You are authorizing Community Health Centers to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

☐ *I authorize the use and disclosure of the information subject to 42 CFR Part 2 for the following purposes: For all future uses and disclosures for my treatment, payment, and health care operations. Information released as a result of this authorization may be redisclosed by the recipient and no longer protected by HIPAA or 42 CFR Part 2. Except, information subject to 42 CFR Part 2 may not be used in legal proceedings without consent or a qualifying court order.*

Patient Signature: _____ Date: _____

Parent, Guardian, or Legal Representative Signature: _____ Date: _____

Describe authority to sign on behalf of patient: _____ Contact number: _____

I hereby revoke this consent on: _____*(date)* *Signature:*_____